



# 2015

## Plan Review Application for a Mobile Food Service Unit

**Operation Information**

(Please Print)

❖ *Service Request*

Operation Name (Doing Business As): \_\_\_\_\_

Mobile Unit Operating Location: ☐ Single Site ☐ Multiple Sites/Route (Include all locations with plan submittal.)

Single Site Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Scope (Briefly describe operation/menu style): \_\_\_\_\_

Former Name: \_\_\_\_\_ Unit Type: ☐ Cart ☐ Vehicle ☐ Trailer ☐ Movable Building

Required Information: WA License Plate # \_\_\_\_\_ VIN # \_\_\_\_\_ WA L & I Sticker # \_\_\_\_\_

❖ *Plan Check N.O.S. # 2***Plan Review Submittal Fee (Make checks payable to: "SKCDPH"). The Plan Review Fee is nonrefundable.**

- ☐ New Operation (\$860 + \$215/hr after 4 hours) (S602) ☐ Mobile changes (\$430 + \$215/hr after 2 hours) (S611)
- ☐ Resubmitted Plan (\$215/hr) (S605) ☐ Cost of Service (\$215/hr) (H009)

**Ownership Information**❖ *Requestor*

Are you the new owner? Yes ☐ No ☐

Name(s): First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_

Business Name (Corp, LLC, etc): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No.'s \_\_\_\_\_

Fax (Optional): \_\_\_\_\_ Email (Optional): \_\_\_\_\_

**Applicant Information** (If different from owner)❖ *Plan Check*

Contact Person (Applicant or Agent) Name(s): \_\_\_\_\_

First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_

Business Name (Corp, LLC, etc): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No.'s \_\_\_\_\_

Fax (Optional): \_\_\_\_\_ Email (Optional): \_\_\_\_\_

**Commissary Information**❖ *Property Information*

Business Name: \_\_\_\_\_

Location/Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Commissary Owner/Contact Person: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Fax (Optional): \_\_\_\_\_ Email (Optional): \_\_\_\_\_ Sewage: ☐ Sewer ☐ Septic System

**Restroom Information** (Must provide restroom availability letter for each stop that lasts longer than 1 hour)❖ *SR Info Add Comment Sec.*

Business Name: \_\_\_\_\_

Location/Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Owner/Contact Person: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Fax (Optional): \_\_\_\_\_ Email (Optional): \_\_\_\_\_ Sewage: ☐ Sewer ☐ Septic System

❖ **Office Use Only**

Date Submitted: \_\_\_\_\_ Risk Classification: \_\_\_\_\_ Service Request SR#: \_\_\_\_\_

Facility Account FA#: \_\_\_\_\_ Account Receivable AR#: \_\_\_\_\_ Invoice IN#: \_\_\_\_\_

Variance SR#: \_\_\_\_\_ Permit Record PR#: \_\_\_\_\_ DPD/DDES #: \_\_\_\_\_

Approval Date: \_\_\_\_\_ Review Time: \_\_\_\_\_ Reviewer: \_\_\_\_\_ Mobile Sticker # \_\_\_\_\_

Notes: \_\_\_\_\_

**PLAN REVIEW APPLICATION SUBMITTAL**

**DISTRICT HEALTH CENTERS**

**DOWNTOWN**  
 401 5<sup>th</sup> Ave, 11<sup>th</sup> Floor  
 Seattle, WA 98104  
 206-263-9566

**EASTGATE**  
 14350 S.E. Eastgate Way  
 Bellevue, WA 98007  
 206-477-8050